



Level I Preadmission Screening (PAS)

Commonwealth of
Massachusetts
EOHHS

This form must be completed by the nursing facility for all individuals who, regardless of payment source, are admitted to a nursing facility. This form must be kept permanently in the resident's medical record. A licensed nurse or licensed social worker employed by the nursing facility must complete both sides of this form **before the applicant's admission**.

Nursing Facility Provider Information	Nursing Facility Applicant Information
Provider Number: 09 _ _ _ _ _	MassHealth ID or SSN:
Name:	Name: Gender: F M
Address:	Address:
Town, ZIP code:	Town, ZIP code:
Telephone Number:	Date of Birth:

Section I. PAS for Mental Retardation or Developmental Disability

1. Does the nursing facility applicant have a documented diagnosis or treatment history of mental retardation or developmental disability? ☐ Yes ☐ No
2. Has the nursing facility applicant received services for mental retardation or developmental disability from an agency that serves individuals with mental retardation and/or developmental disability? ☐ Yes ☐ No
3. Does the nursing facility applicant exhibit any evidence that may indicate mental retardation or developmental disability? ☐ Yes ☐ No

Section II. Convalescent Care

Is the nursing facility applicant seeking admission for convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay? ☐ Yes ☐ No

Section III. Level I Determination for Mental Retardation or Developmental Disability (Check all that apply.)

- ☐ Level II PAS is not indicated because there is no diagnosis or evidence of mental retardation or developmental disability.
- ☐ Level II PAS is not indicated because the applicant is seeking admission for convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay.
- ☐ **Level II PAS is indicated and must be completed before admission.** Date of completion: _____
- ☐ Approved by DMR for nursing facility admission. (The DMR approval letter must be in the medical record.)

Date of nursing facility admission: _____

Comments: _____

Signature: _____ RN, LPN, LSW Date: _____ Time: _____
(Circle one.)

NOTE: You must notify DMR only when MR/DD is indicated.

Did you call and notify DMR (508-384-1644) on the day of admission? ☐ Yes (Date) _____ ☐ No

Did you fax this page within 48 hours to DMR (508-384-5562)? ☐ Yes (Date) _____ ☐ No

Please complete other side. →

Name of Applicant: _____

Section IV. PAS for Mental Illness

1. Does the nursing facility applicant have a documented diagnosis or treatment history of any of the following major mental disorders? (Check all that apply.)

Psychoses

- ☐ schizophrenia
☐ paranoia
☐ atypical psychosis

Affective Disorders

- ☐ schizo-affective disorder
☐ bipolar disorder (formerly manic depression)
☐ unipolar depression more than 10 years with psychiatric hospitalization or ECT psychoactive medication (date of diagnosis: _____)

Severe Anxiety and Somatoform Disorders (All must apply for Level II PAS referral.)

- ☐ two years' duration with documented symptoms in the last six months
☐ inpatient psychiatric treatment for anxiety disorder
☐ psychoactive medication(s) administered for anxiety disorder

2. Does the nursing facility applicant exhibit any evidence of a major mental disorder? ☐ Yes ☐ No

3. Has the nursing facility applicant ever received any of the following treatments?

- a. inpatient or outpatient psychiatric treatment ☐ Yes ☐ No
b. electro-convulsive therapy ☐ Yes ☐ No
c. psychoactive medications ☐ Yes ☐ No

If yes: name of current medication(s) and dosage: _____
Reason for administration: _____

If you have not checked anything in Section IV, skip Section V and go on to Section VI.

Section V. Primary Diagnoses/Conditions

Does the nursing facility applicant have any of the following diagnoses or conditions or meet any of the following descriptions? (NOTE: End Stage (ES) - severe, debilitating and bed-bound or bed-to-chair). Check all that apply.

- ☐ Alzheimer's disease or other dementia (requires supporting documentation) ☐ severe brain injury
☐ comatose ☐ ES COPD with 24-hour oxygen
☐ ventilator dependent ☐ ES CHF with 24-hour oxygen
☐ terminal illness with less than six-month prognosis as certified by a physician ☐ ES Amyotrophic Lateral Sclerosis (ALS)
☐ unipolar depression, less than 10 years' duration (date of diagnosis: _____) ☐ ES Huntington's Chorea
☐ convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay (This does not include a psychiatric hospitalization.) ☐ ES Parkinson's disease

Section VI. Level I Determination for Mental Illness

 (Check all that apply.)

- ☐ Level II PAS is not indicated because there is no diagnosis or evidence of mental illness as noted in Section IV.
☐ Level II PAS is not indicated because the applicant has one of the diagnoses or conditions in Section V.
☐ **Level II PAS is indicated and must be completed before admission.** Date of completion: _____
☐ Approved by Health and Education Services (HES) for the Department of Mental Health for nursing facility admission. (The HES approval letter must be in the medical record.) Contact HES at 978-745-2440, x126.

Comments: _____

Signature: _____ RN, LPN, LSW Date: _____ Time: _____
(Circle one.)

Level I and Level II PAS must be kept permanently in the medical record.